Medwork Independent Review
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IN PROCESS
Comprehensive
Independent Review Organization

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
WORKERS' COMPENSATION - WC

DATE OF REVIEW: 3/2/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Chronic pain management program.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Physical Medicine/Rehabilitation Physician.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☐ Upheld (Agree)
☒ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:
Claimant was injured on xx/xx/xx. He fell between a truck and a loading deck, striking his right knee. Initially, he went to a medical center, diagnosed with brushing and contusions of the knee. He continued to have symptoms of pain in the right knee and was initially seen on 11/07/2014. He had been undergoing physical therapy, utilizing analgesics and despite this, still had symptoms of pain.

The claimant received a right knee injection on 09/19/2014 without any significant benefit. Remained on analgesics including ibuprofen, tramadol, and during this time, remained on light duty status. On 09/11/2014, the claimant was determined to have reached medical maximum improvement in June 2014. FCE performed on 11/11/2014. He required a PDL to maintain his job description and because he did not reach this PDL on the functional capacity evaluation, there was a recommendation to pursue multidisciplinary chronic pain management program.

Diagnostic imaging has included 3 views of the right knee and MRI of the knee on 06/03/2014, revealed mild subcutaneous edema along the anterolateral aspect of the knee, centrally at the level of the lateral patellar retinaculum, most consistent with the contusion or inflammation. There was no evidence of internal derangement.

In summary, this is a claimant who underwent conservative management inclusive of physical therapy and occupational therapy, underwent intra-articular steroid injection and despite these measures continued

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to have pain ultimately leading to a surgical opinion and at this evaluation, he was deemed nonsurgical. He also was diagnosed with axis I disorder including adjustment disorder with mixed anxiety and depressed mood.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The claimant has clearly exhausted on all conservative measures allowing for passage time for natural tissue healing, working at light duty status with work restrictions, utilizing analgesics including NSAID therapy, mild opioid agonist like tramadol and muscle relaxers such as Flexeril. He underwent intra-articular steroid injection, which would be considered as the next step in the management of uncontrolled knee pain and ultimately an MRI, which revealed only degenerative changes of the lateral patellar retinaculum and ultimately deemed non-surgical with axis I disorder of anxiety and depressive disorder.

Clearly, he has exhausted all conservative measures as not deemed surgical, but continues to have pain with mood disorder. He has met baseline criteria for ODG to move forward with the first 10 hours of the program to help aid and functional capacity, which he should be at heavy PDL before he can get back to the line of work.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**